STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012140	A. BUILDING: _____ B. WING _____	07/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARIGOLD ESTATES	3240 BARNEY AVENUE PEKIN, IL 61554

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Z 000	COMMENTS Annual Certification	Z 000		
Z9999	FINDINGS Statement Licensure Violations: 350.620a) 350.1060e) 350.3240a) 350.3240f) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually Section 350.1060 Training and Habilitation Services e) An appropriate, effective and individualized program that manages residents' behaviors shall be developed and implemented for residents with aggressive or self-abusive behavior. Adequate, properly trained and supervised staff shall be available to administer these programs. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or	Z9999	Attachment A Statement of Licensure Violations	

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Z9999	Continued From page 1 neglect a resident f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. These regulations are not met as evidenced by: A facility "Abuse and Neglect Investigation and Report Form" with an additional incident report stated an act of sexual abuse occurred on 5/17/18 between R4 and Z1 (a Visitor at the facility). Report states, "(Z1) had been on a visit (at the facility) since 5/7/18 and sharing a room with (R4) since visit began. This admission has been paused at this time, but he is still under our care, because his stepdad does not want him to return to his home. On 5/18/18 around 4pm, (R4) brought his cell phone to E1 (RSD-Residential Service Director) and asked her to speak to his counselor on his phone. Counselor reported, per (R4) request, to RSD that he had put his penis in (Z1's) rear-end the night before." The report continues, "Due to (R4's) admission of actions taken, and it felt that (Z1) is incapable of consent, it is deemed that (R4) did sexually abuse (Z1)." E3, Administrator, confirmed during an interview	Z9999		

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Z9999	Continued From page 2 on 6/18/19 at 2pm that she did not feel Z1 has the mental ability to understand consent to a sexual act. A Nurses note from 5/18/18, E4, Registered Nurse, documented she interviewed Z1. "(Z1) is a non-verbal male but understands when you talk to him. (Z1) is profound range." The note continues E4 said to Z1, "I heard that someone had hurt you last night. He looked at me, turned slightly to the right and pointed to his buttocks." Record review of a Psychological Assessment Report completed on 6/5/17 shows Z1 was then a 24 year old Caucasian male diagnosed with Autism Spectrum Disorder and Intellectual Disability. Z1's Full Scale IQ is 43, Z1's Adaptive Behavior Overall Age Equivalent is 4 years, 5 months. Evaluator described Z1 as not making eye contact and did not always seem to understand what was expected of him. Evaluator states Z1 is verbally expressive, frequently exhibiting echolalia and repeating the same phrases over and over. Record review of R4's Inter-Disciplinary Team (IDT) Evaluation dated 9/1/17 shows he is his own guardian and has diagnoses which include Mild Intellectual Disability, Bipolar Disorder, Schizophrenia, Attention Deficit Hyperactivity Disorder (ADHD), Impulse Control Disorder. R4's IQ is 61 and his ICAP is 8 years 2 months. R4's IDT Evaluation states he displays agressive behaviors in the form of verbal aggression and yelling when he becomes upset. He "recently displayed sexually innappropriate behaviors by borrowing his roomate's tablet, filming himself masturbating and sending it over a messenger application to his ex-girlfriend."	Z9999		

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Z9999	Continued From page 3 On 11/29/17, E2, Qualified Intellectual Disability Professional (QIDP), developed a Behavior Management Plan (BMP) for R4 for the maladaptive behavior of "Sexual Inappropriateness/24 hour supervision". The BMP reads, "(This facility) received DCFS (Department of Children and Family Services) paperwork concerning R4's history of sexually abusing his younger brother. (R4) admitted to sexually abusing his younger brother, who was 11 years old a the time, through sexual penetration and forcibly touching his genitals. (R4) has requested that we help keep him on a straight path. (R4) knows that this kind of sexual behavior is seriously inappropriate, and states that he sometimes has urges that he needs help resisting. (R4) will be put on 24 hour supervision at all times. This is to assure that (R4) does not act on any inappropriate urges towards any other residents or members of the community. This is pertinent to keep both (R4) and others safe." The plan has the following approach: "(R4) requires supervision at all times either by staff or by family members. While in the public, (R4) is to remain within site of the person who is supervising him. Staff will knock on doors and check for occupancy in a room prior to (R4) entering the room. If someone is present, (R4) will wait outside until the area is vacated. " Staff responsible to implement this plan include: "All facility and workshop staff." Program location includes; "Daily, at all times, across all environments." In an interview on 6/19/18 at 1:40pm with Z2, Day Training Staff, stated the day training site first	Z9999		

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Z9999	Continued From page 4	Z9999		

they knew of R4's Behavior Management Plan which was written 11/29/17 was on 5/31/18 when Z2 received a revised copy as an attachment in an email prior to a meeting about the 5/17/18 incident.

In an interview on 6/20/18 at 1:14pm, E2 was asked if she had reproducible evidence that she provided R4's BMP to the day training site to be implemented. E2 stated, "I did not."

E2 was asked when the facility found out R4 had a history of sexually abusing others. E2 stated, "about 30 days after his admission" and then referred to the DCFS documents which were provided to them dated 11/6/17.

These DCFS documents have an incident on 3/8/11 involving R4 and his brother which reads, "(R4) is being indicated for sexual penetration of 11 year old (brother). The child describes several incidents where his brother put his finger and his penis in (the brother's) anus. (R4) confessed to his mother about this. (R4) was charged by the states attorney with the crime. A CAC (Child Advocacy Center) interview was done and the children were credible. Credible evidence found to support the allegation.

DCFS Supervisory Note dated 3/14/11 addresses safety risk and states they "discussed completing a safety plan with the mother so that the 15 y/o would not have unsupervised access to any of the other children, including that he not be allowed to sleep in the same room as the other children."

E2 confirmed this was the information which was provided to the facility by DCFS. E2 was asked if the facility knowingly put a low functioning, Autistic visiting individual in the same room as R4

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Z9999	Continued From page 5 from 5/7/18 until the date of the incident of sexual abuse which occurred on 5/17/18. E2 confirmed the facility placed Z1 in R4's room during his visit. E2 stated "It all makes sense in hindsight. We were just blindsided by this. R4 was doing so good, I guess we let our guard down." E2 confirmed during interview on 6/20/18 at 1:14pm, R4's 11/29/17 BMP had not been implemented by staff as she intended it to be. E2 was asked if there were other allegations of abuse by R4 while he resided in the facility. E2 provided documentation of an incident which occurred on 2/21/18 between R4 and his room mate (at the time) R5. The report states on 2/21/18 another resident (R6) reported to staff that R4 and R5 were "in their bedroom naked and doing inappropriate things". When the facility investigated, R4 and R5 stated they were getting their pajamas on. R5's mother was notified and picked him up for a visit on 2/23/18. R5's mother reported back to the facility that R5 told her R4 was laying on his bed naked and asked R5 to 'F' him. Following this incident, R5 was moved to a different bedroom. E2 confirmed R4 had no room mate from 2/24/18 (when R5 moved) until Z1 came for a visit in May, 2018 and was assigned to the same room as R4 from 5/7/18 until 5/18/18 (when the incident was reported). E2 confirmed R4's BMP had been developed but not properly implemented by staff the night of 5/17/18 when R4 and Z1's incident of sexual abuse took place in their bedroom. A undated facility policy titled "Facility System for Maltreatment, Abuse, Neglect, Exploitation and Complaint Resolution" was provided by E3, Facility Administrator on 6/19/18 at 2pm. This	Z9999		

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Z9999	Continued From page 6 states, "It is the policy of this facility to ensure that residents are not subject to physical, verbal, sexual or psychological abuse/neglect/maltreatment/exploitation. This includes but is not limited to insuring that indivdiaul residents are free from serious and immediate threats to their physical and psychological health and safety." Sexual abuse is defined as any act of sexual contact (inappropriate contact between an individiual and another person involving either an employee's genetal area, anus, buttocks or breasts, or an indivdiiual's genital area, anus, buttocks or breasts(, sexual penetration, sexual coercion, or sexual exploitation of an individual. It includes, but is not limited to, sexual harassment, exhibitionism, sexual coercion, sexual contact sexual assault, rape or any sexual activity that occurs when an individual cannot or does not consent. A policy on Visitors staying overnight to the facility was requested. E3 stated at the time of the interview, the facility had no such policy in place. During a phone interview with E1, Residential Service Director, on 6/22/18 at 3:04pm, E1 confirmed there had been no additional training on the accurate implementation of BMP's since the 5/17/18 incident. (B)	Z9999		